OFFICE OF POLICY, PROCEDURES, AND TRAINING

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POLICY BULLETIN #18-44-OPE

REOPENING CERTAIN CASH ASSISTANCE CASES CLOSED LESS THAN 30 DAYS

Date: July 25, 2018	**Subtopic(s):** Cash Assistance, Reopen, POS

Purpose

The purpose of this policy bulletin is to alert all Job Center and Fair Hearing and Conference (FH&C) staff of a change in the policy for when a Cash Assistance (CA) case can be reopened without a new application. This policy bulletin is informational for all others.

Effective August 13, 2018 CA cases closed less than 30 days with the following CA reason codes may now be reopened without requiring a new application:

- **V20** – Failure to Provide Verification
- **G36** – Failure to Complete the TA (6 Month) Mail in Recertification For Cases on 12 Month Recertification Schedule (SNAP Separate Determination)
- **G37** – Failure to Complete the TA (6 Month) Mail in Recertification For Cases on 12 Month Recertification Schedule (No SNAP Separate Determination)

In order to be reopened, the participants must fully comply with the requirement that led to the termination of their benefits. For example, if a case was closed with CA reason code **V20** and the participant was asked to return paystubs and a bank statement but only returns with the paystubs, staff must not reopen the case at that time.

The reopening can only be done at the center in which the case was closed. If a participant reports to a different Job Center, they will not be presented with the routing options to re-open their case.

For all other case closings, an application is still required.

Rent Supplement Programs

Rent Supplements

Regardless of the CA closing reason, if the participant was in receipt of a rent supplement such as the Family Homelessness and Eviction Prevention Supplement (FHEPS), it must be restored to the case when reopening the case whether it was closed in error or if the original closing was correct.

V20 – Failure to Provide Verification

Closed in Error

For cases closed with CA reason code **V20**, the Case Management Unit (CMU) will be responsible for first verifying that the closing was correct using the **Review Case** activity in POS along with any other necessary systems. If the case was closed in error, including whether the documents requested were submitted or the failure to honor any reasonable accommodations, the case must be reopened using the **Re-Open CA Case** activity with CA reason code **Y42** (closed in error) and all benefits, including any rental supplements, must be restored to the date of closing.

Closing Action Correct

Core/Mandatory documentation only includes documents required to prove continuing eligibility. It does not include documents that would only impact benefit amounts such as proof of shelter expenses.

If it is determined that the closing was correct, CMU must ensure that the participant submits all outstanding core/mandatory documentation. Once all documentation is provided, the case may be reopened. The food and other (F&O) must be restored to the date of compliance while rent must be issued back to the date of closing, if any cycles were missed, including any rental supplements such as FHEPS.

If the participant does not submit all of the outstanding documents, the case cannot be reopened. The individual must be advised of:

- The documents that must be returned;
- The last day by which the documents can be returned (the 30th day); and
- Their option to reapply that day or at any point thereafter.

G36/G37 - Failure to Complete the TA (6 Month) Mail in Recertification For Cases on 12 Month Recertification Schedule

For cases closed either with CA reason codes **G36** or **G37**, FH&C will be responsible for first determining if the case was closed in error. This includes verifying that the mailing address was correct, the completed and signed Mail-in Recertification/Eligibility Questionnaire (**M-327h**) is not already in the HRA OneViewer, and that any reasonable accommodations were honored.

Closed in Error

If it is determined that the case was closed in error, FH&C will submit a Routing Control Sheet **(W-270**) to the Job Center clearly identifying that the case was closed in error and that benefits, including any rent supplements must be issued back to the date of the closing. The Job Center must then reopen the case using the **Re-Open CA Case** Activity with CA reason code **Y42** (closed in error) and issue the appropriate benefits.

If the closing error was because the **M-327h** was sent to the wrong address, FH&C staff should ask the participant to complete and sign the mailer. FH&C staff must indicate on the **W-270** what the correct address is, if the closed case does not have the correct one. In these instances, the Job Center must send an **M-3g** from POS once the case is open to ask for any documentation that should have been submitted with the **M-327h** if it had gone to the correct address originally.

Closing Action Correct

If FH&C determines that the closing was correct, the participant can provide their completed and signed **M-327h**, or must be provided an **M-327h** to complete and sign. FH&C staff must review the **M-327h** and ask the participant for any documentation required to support any changes indicated on the **M-327h** or any earned income information (regardless of whether or not it is a change).

Note: Verification of unearned income is only required if a change in the unearned income is being reported.

Does Not Have All Documents

Documentation required

If the participant does not have any of the required documentation, FH&C staff cannot accept the signed and completed **M-327h** and must inform the participant of:

- The documentation required to reopen the case;
- The last day by which the participant can return the documentation along with the signed and completed **M-327h**; and
- The individual's right to reapply that day or at any point thereafter.

Has All Necessary Documentation

All Documentation submitted with **M-327h**

If the participant has all required documentation, or returns with all required documentation by the 30th day, FH&C staff must scan and index the signed and completed **M-327h**, along with all other documentation the participant submits at that time, into the electronic case record. FH&C staff must then submit a **W-270** to the Job Center for processing of the reopening. The **W-270** must clearly indicate that:

- The case is being reopened solely because of the participant's compliance
- F&O must be issued from the date of compliance and rent must be issued back to the date of closing, if any cycles were missed.
- Documentation is available in the Viewer

  Note: Earned income verification must be provided even if there is no change being reported

FH&C staff must also post Action Code **702W** (W-270 Request Forwarded to JC Operations) in the New York City Work Accountability and You (NYCWAY) system. This will place the case on the FHRTE worklist to be monitored by Job Centers daily.

Job Center Responsibility for G36/G37

Job Center Operations Responsibility for G36/G37

The Job Center must comply with the instructions on the **W-270** to reopen the case and issue benefits accordingly, including the restoration of any rental supplements such as FHEPS.

Immediate Needs Identified

If the individual indicates to either CMU or FH&C that they have an immediate need that must be addressed on the same day, the individual should be advised that they have the right to reapply, be interviewed that day, and if eligible, receive a same day immediate needs grant. The individual should also be made aware of all other application requirements such as the application time frames and the need to comply with potential applicant referrals (i.e. BEV, OCSE, etc.).

If the individual chooses this, the CMU worker must initiate an application interview in POS and proceed as per current procedure for applications. If the individual is with FH&C and chooses to reapply, they must be routed to CMU for an application interview using MONIQ.

System Enhancements

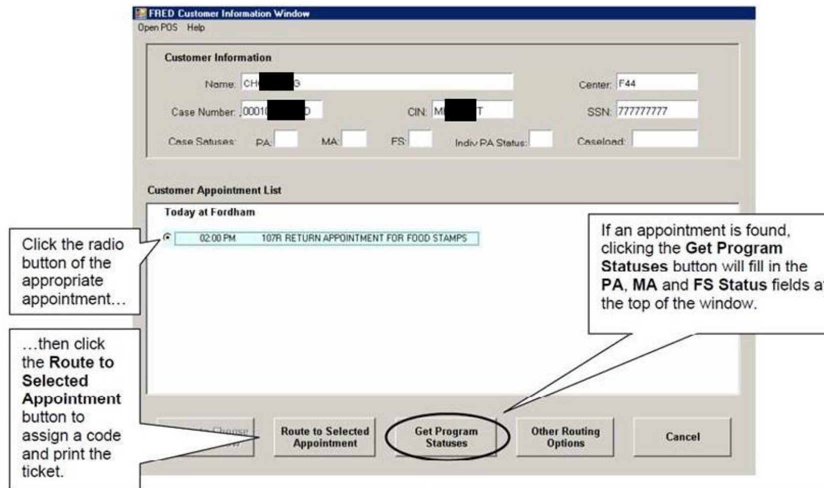
In order to implement this policy change, both the Paperless Office System (POS) as well as Model Office Systems have been modified.

<u>Model Office Systems</u>

Front Door Reception

In Job Centers with Front Door Reception (FDR), when an individual swipes their Common Benefit Identification Card (CBIC) or a case search is done by FDR staff, the system will look to see the status of the case. If the case is closed less than 30 days with CA reason code **V20, G36,** or **G37**, the system will recognize this and display it as “CA Reopen for V20 Closings” or “FH&C Reopen for G36/G37 Closing” in the **Current Appointment List** with the specific closing code (see screen shot on the following page) if the participant is in the center in which the case closed.

FDR staff will be able to select the appointment and for closing code **V20**, issue the new **CA Reopen** ticket to route the individual to CMU. If the CA closing code is **G36** or **G37**, the system will generate a ticket to FH&C.



Other Routing Options

If the individual indicates that they are in the center for another reason (i.e. apply for SNAP, apply for a One-Shot Deal, etc.) FDR staff must use **Other Routing Options** to route the individual to the appropriate area.

Self-Service Kiosk

In Job Centers with self-service kiosks, if the individual correctly identifies themselves, the system will search to determine the status of the case. If the case is closed less than 30 days with CA reason code **V20, G36,** or **G37** the individual will be presented with a new option to reopen their CA case or to reapply (see screen shot on next page).

If the individual selects the reopen option and the CA closing code was **V20**, the kiosk will generate a **CA Reop** ticket and route the individual to CMU. Designated staff in CMU must monitor this queue to ensure all participants are seen.

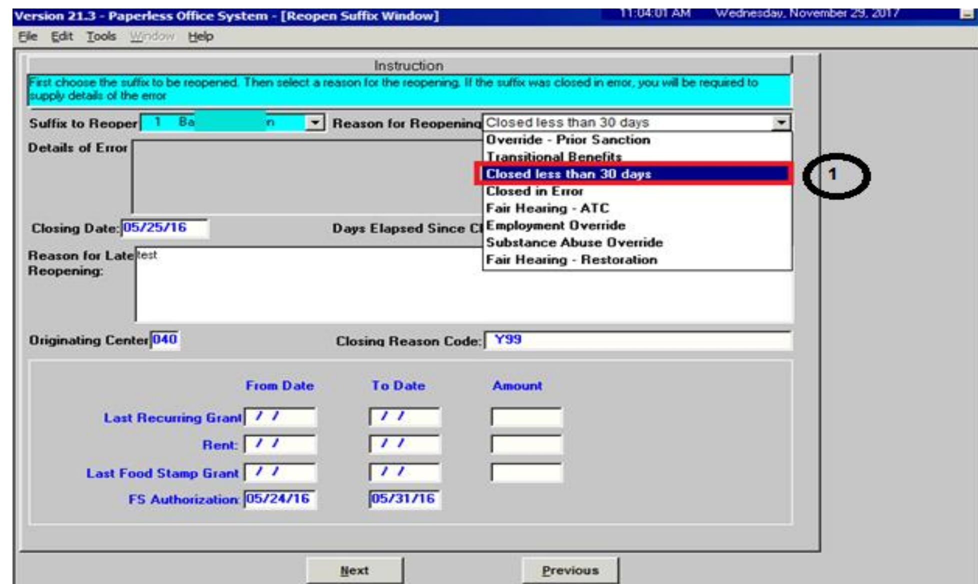
If the individual selects the reopen option and the CA closing code was **G36** or **G37**, the kiosk will generate an **FH&C** ticket and route the individual to FH&C. FH&C staff are responsible for monitoring this queue as part of the regular course of business.

Paperless Office System (POS)

Refer to PB #18-12-SYS for additional POS information

To accommodate this policy change, a new option has been added to the **Re-Open CA Case** activity in POS. When a worker is reopening a case closed less than 30 days due to compliance, they must use this activity. Once the activity is started, staff must select “Closed less than 30 days” from the drop down menu as the reason for reopening (see screen shot below).

By selecting this option, POS will set the case status to **AC** (active) with the new CA Opening Code **Y16** (CA Reactivation – closed less than 30 days). If the case does not meet the criteria, an error message stating “Original Case was closed for 30 or more days. You cannot reopen with this reason” will display. Once the worker clicks OK to remove the error message, the selection of the reason will be cleared. Any F&O benefits issued under this process must only go back to the date of compliance.



Effective August 13, 2018

Reference:
18 NYCRR 350.4 (a) (5)

Related Item:
PB #18-12-SYS

Attachments:

M-327h	Mail-In Recertification / Eligibility Questionnaire (Rev. 10/02/2014)
M-327h (S)	Mail-In Recertification / Eligibility Questionnaire (Spanish) (Rev. 10/02/2014)
W-270	Routing Control Sheet (Rev. 7/05/11)

Date: ____________________

Case Number: ____________________

Case Name: ____________________

Center: ____________________

Caseload: ____________________

Mail-in Recertification/Eligibility Questionnaire

To determine your continued eligibility for Temporary Assistance (TA) and Supplemental Nutrition Assistance Program (SNAP), you must answer every question, sign, date, and return this form in the enclosed postage-paid envelope to the **Family Independence Administration, P.O. Box 637, Canal Street Station, New York, NY 10213-0195** by: ____________________.
(Return Date)

For TA, this form is considered a mail-in recertification form. For SNAP, this is an Eligibility Questionnaire.

- You must enclose copies of letters or documents that verify the changes you report. In addition, if you or your family member has a job (earned income), you must submit the last four paystubs *or other proof of gross income earned and the number of hours worked during the last 30 days* even if the wages have not changed.
- Failure to return the form or returning it without the required verification may result in the closing of your case or reduction of benefits.

1. Do you still need:

   Cash Assistance? ☐ Yes ☐ No SNAP? ☐ Yes ☐ No Medical Assistance? ☐ Yes ☐ No

   If No, your benefit will be stopped.

2. Did anyone **move into** or **out of** your household since the last time you reported the number of persons in your household (including births)? ☐ Yes ☐ No
   - If Yes, provide the information requested below.
   - If they want to apply for assistance an application must be completed.
   - If you are reporting a newborn enclose a copy of a birth certificate for verification.

Social Security Number	Name	Relationship to You	Moved In	Moved Out	Date

SAMPLE

3. Other than Cash Assistance, did you, or anyone in your household, have a change in income? Has anyone begun receiving any new or increased income or lost income from any of the following sources since the last time you reported your income?

   If you check ☑ Yes, indicate the amount you receive and whether this amount is new, more, or less. If you or a family member has a job (earned income) you must fill in part B, Employment, and submit photocopies of the last 4 paystubs *or other proof of gross income earned and number of hours worked during the last 30 days* even if the wages have not changed.

Source of Income		Amount	New	More	Less
A. Contributions	☐ Yes ☐ No	$__________			
B. Employment (whether new or not and whether more or less than previously reported) Please indicate the number of hours you work per week__________.	☐ Yes ☐ No	$__________			
C. Unemployment Insurance Benefits (UIB)	☐ Yes ☐ No	$__________			
D. Supplemental Security Income (SSI)	☐ Yes ☐ No	$__________			
E. Social Security Income other than SSI	☐ Yes ☐ No	$__________			
F. Child Support (including court-ordered payments)	☐ Yes ☐ No	$__________			
G. Veteran's or other military benefits	☐ Yes ☐ No	$__________			
H. Other Income	☐ Yes ☐ No	$__________			

Case Number: ______________________

4. Have there been any changes in the following since you last reported to us?

A. Rent costs: ☐ Yes ☐ No

If Yes, Increase ☐ Decrease ☐ New amount $ ____________ (Enclose proof of change)

B. Is someone pregnant or disabled? ☐ Yes ☐ No

If Yes, provide name (enclose medical proof): ______________________________

C. Resources (e.g., motor vehicle, bank account, etc.): ☐ Yes ☐ No

If Yes, explain (enclose photocopy of bank statement, car title, etc.): ______________________________

D. Child support you pay to someone outside your household: ☐ Yes ☐ No

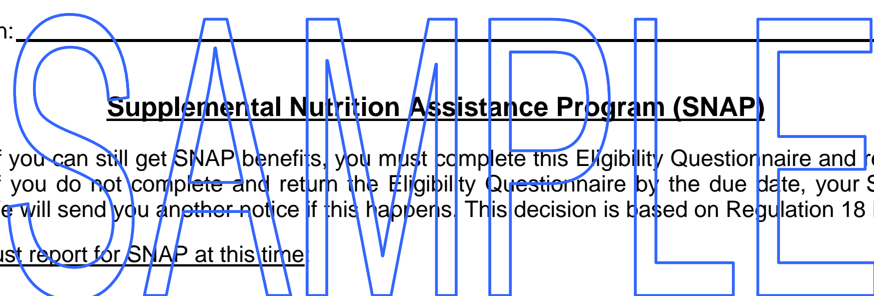
If Yes, Increase ☐ Decrease ☐ New amount $ ____________ (Enclose proof of court order)

E. Medical expenses paid by household member who is disabled or who is 60 years old or older: ☐ Yes ☐ No

If Yes, explain change: ______________________________

F. Other changes: ☐ Yes ☐ No

If Yes, explain: ______________________________



Supplemental Nutrition Assistance Program (SNAP)

In order to determine if you can still get SNAP benefits, you must complete this Eligibility Questionnaire and return it by the date on **page 1** of this form. If you do not complete and return the Eligibility Questionnaire by the due date, your SNAP benefits will be reduced or stopped. We will send you another notice if this happens. This decision is based on Regulation 18 NYCRR 387.17.

List of changes you must report for SNAP at this time:

- Changes in any **source of income** for anyone in your household.
- Changes in your household's total **earned income** when it goes up or down by more than $100 a month.
- Changes in your household's total **unearned income from a public source** such as Social Security Benefits or Unemployment Insurance Benefits when it goes up or down by more than $50 a month.
- Changes in your household's total **unearned income from a private source** such as child support payments or private disability insurance when it goes up or down by more than $100 a month.
- Changes in the amount of court-ordered **child support you pay** to a child outside of your SNAP household.
- Changes in **who lives with you**.
- **If you move**, your new address and your new rent or mortgage costs, heat costs, and utility costs.
- **A new or different car**, or other vehicle.
- Increases in your household's **cash, stocks, bonds, money in the bank** or savings institution if the total cash and savings of all household members now amounts to more than $2,250 for a household without an elderly or permanently disabled household member or $3,250 for a household with an elderly or permanently disabled household member.
- If anyone in your SNAP household is an Able Bodied Adult Without Dependents (ABAWD), you must tell us if that individual's participation in employment or other work activities falls below 80 hours a month within 10 days after the end of that month.

MEDICAL ASSISTANCE — You must immediately report any changes in your address, income, resources or household size to this agency. You will be notified if your Medical Assistance coverage changes.

You must enclose copies of letters or documents that verify the changes you report. In addition, if you or your family member has a job (earned income), you must submit the last four paystubs *or other proof of gross income earned and the number of hours worked during the last 30 days* even if the wages have not changed.

If anyone in your SNAP household is an Able Bodied Adult Without Dependents (ABAWD), you must tell us if that individual's participation in employment or other work activities falls below 80 hours a month within 10 days after the end of that month.

Authorization To Repay Public Assistance Benefits From Retroactive SSI

I authorize the Commissioner of the Social Security Administration (SSA) to use my first payment of SSI (i.e. my retroactive SSI payment) to reimburse the local Social Services District (SSD) for Public Assistance (PA) the SSD pays me from State or local funds while SSA decides if I am eligible for Supplemental Security Income (SSI). SSA will not reimburse the SSD for PA that was paid using any federal funds.

I will be bound by this authorization only if the State gives notice to SSA that I and an SSD representative have signed it. The State must give notice within 30 calendar days of matching my SSI record with my State record. SSA will not accept it after 30 calendar days. Instead, SSA will send me my retroactive SSI payment under SSA rules.

Only my first payment of SSI can be used. If my first payment is larger than the amount owed to the SSD, SSA will send the rest to me under its rules.

SSA can reimburse the SSD in two situations:

(1) It will repay the SSD if I apply for SSI and SSA finds me eligible.

(2) It will repay the SSD if my SSI benefits are reinstated after termination or suspension.

SSA will only reimburse the SSD for PA it paid me during the time I am waiting for an SSA determination of eligibility. This is called "interim assistance". The period begins (1) with the first month I become eligible for payment of SSI benefits, or (2) on the first day I am reinstated after my SSI was suspended or terminated. The period includes the month SSI payments actually begin. If the SSD cannot stop my last PA payment, the period ends the next month.

SAMPLE

No later than 10 days after SSA reimburses the SSD, the SSD must send me a notice telling me the amount of interim assistance paid. The notice will also tell me that SSA will send me a letter telling me how any remaining SSI money owed to me will be sent by SSA and, that if I do not agree with a state decision, how I can appeal the decision to the state.

Under its rules, SSA may use the date I sign this authorization as the date I first become eligible for SSI. It will do this only if I apply for SSI within the next 60 days.

This authorization applies to any SSI application or appeal I now have pending before SSA.

This authorization terminates if my SSI case is completely decided. It terminates when SSA first pays me. The State and I can also agree to terminate the authorization. I must sign a new authorization consistent with NYS rules if I reapply for SSI after this authorization terminates, or if I file a new SSI claim while I have an SSI application or appeal pending.

I will be given an opportunity for a fair hearing if I disagree with a decision the SSD made about reimbursement.

I received a copy of the pamphlet called "What You Should Know About Social Services Programs." I understand what it says about interim assistance.

I swear (or) affirm that the information on this form is true and correct.

Name (please print): ______________________________

Signature: ______________________________ Date: ______________

Signature of Husband/Wife or Authorized Representative: ______________________ Date: __________

WARNING: Federal and State law provides for penalties of fine, imprisonment or both if you do not tell the truth or if you conceal or fail to disclose facts regarding your continuing eligibility for assistance. Regulations require that you immediately notify this Agency of any changes in needs, income, resources, living arrangements or address.

Worker Signature: ______________________________ Date: ______________

NOTE: The last part of this form is an application to register to vote. If you would like help filling out the voter registration application form, ask your Worker. Applying to register or declining to register to vote will not affect the amount of assistance that you will be given by this agency. Return this form to the Agency whether it has been completed or not.

Human Resources Administration
Department of Social Services

Family Independence Administration

Form M-327h (S) (LDSS-4887 SP) (page 1 of 3) Rev. 10/02/2014 LLF

Fecha: ____________________

Número del Caso: ____________________

Nombre del Caso: ____________________

Centro: ____________________

Unidad de Casos ____________________

Cuestionario de Recertificación/Elegibilidad Por Correo

Para determinar su elegibilidad continua para Asistencia Temporaria (TA) y beneficios del Programa de Asistencia de Nutrición Suplementaria (SNAP), usted debe contestar todas las preguntas, firmar, fechar y devolver este formulario en el sobre prepagado adjunto a la **Family Independence Administration, P.O. Box 637, Canal Street Station, New York, NY 10213-0195** para el día ______________.

(Fecha de Regreso)

Para el Programa de Asistencia Temporal (TA), este formulario se considera un formulario de recertificación por correo. Para el programa de SNAP, se considera un cuestionario de Elegibilidad.

- Usted debe adjuntar copias de las cartas o los documentos que comprueben los cambios que reporte. Además, si usted o un familiar tiene un trabajo (ingreso salarial) debe presentar los últimos cuatro talones de paga *u otro comprobante de ingreso bruto salarial y el número de horas laborales durante los últimos 30 días*, aún cuando los ingresos no hayan cambiado.
- Su caso puede ser cerrado o sus beneficios pueden ser reducidos, si no devuelve el formulario, o lo devuelve sin los comprobantes estipulados.

SAMPLE

1. ¿Aún necesita:

   Asistencia en Efectivo? ☐ Sí ☐ No Beneficios de SNAP? ☐ Sí ☐ No Asistencia Médica? ☐ Sí ☐ No

   Si su respuesta es No, sus beneficios serán suspendidos.

2. ¿Se han **mudado** a/de su hogar miembros del grupo familiar desde la última vez que usted reportó el número de integrantes de su hogar (incluyendo los recién nacidos)? ☐ Sí ☐ No

   - Si contestó que Sí, proporcione los datos solicitados más abajo.
   - Si desean solicitar asistencia se debe llenar una solicitud.
   - Si está reportando a un recién nacido, favor de adjuntar como comprobante una copia de la partida de nacimiento.

Número de Seguro Social	Nombre	Parentesco con Usted	Se Mudó al Hogar	Se Mudó del Hogar	Fecha

3. Aparte de lo que recibe en Asistencia en Efectivo, ¿usted o alguien en su hogar ha experimentado una modificación de ingreso? ¿Ha comenzado a recibir algún nuevo o mayor ingreso o ha perdido ingreso de cualquiera de las siguientes fuentes desde la última vez que usted reportó su ingreso?

   Si usted marcó ☑ Sí, indique la cantidad que recibe y si esta nueva cantidad representa una pérdida, un aumento, o una nueva fuente de ingresos. Si usted o un familiar tiene un trabajo (ingreso salarial) se debe llenar la parte B, Ocupación, y presentar fotocopias de los últimos cuatro talones de paga *u otro comprobante de ingreso bruto y el número de horas laborales durante los últimos 30 días*, aún cuando sus ingresos no hayan cambiado.

Fuente de Ingreso		Cantidad	Nueva	Aumento	Reducción
A. Contribuciones	☐ Sí ☐ No	$__________			
B. Empleo: (si es nuevo o no, y si es más o menos de lo reportado) Favor de indicar el número de horas que trabaja por semana __________.	☐ Sí ☐ No	$__________			
C. Beneficios de Seguro de Desempleo (UIB)	☐ Sí ☐ No	$__________			
D. Seguridad de Ingreso Suplementario (SSI)	☐ Sí ☐ No	$__________			
E. Ingreso de Seguro Social que no sea de SSI	☐ Sí ☐ No	$__________			
F. Manutención de niños (incluyendo pagos dictados por el tribunal)	☐ Sí ☐ No	$__________			
G. Beneficios de veteranos u otros beneficios a militares	☐ Sí ☐ No	$__________			
H. Otros ingresos	☐ Sí ☐ No	$__________			

Administración de Recursos Humanos
Administración de la Independencia Familiar

Número del Caso: ____________________

4. ¿Se han dado cambios en las siguientes situaciones desde la última vez que usted nos reportó?

A. Costo de alquiler: ☐ Sí ☐ No
Si respondió Sí, Aumento ☐ Reducción ☐ Nueva cantidad $__________ (Adjunte comprobante del cambio).

B. Hay una persona embarazada o incapacitada: ☐ Sí ☐ No
Si respondió Sí, proporcione el nombre (adjunte comprobante médico): ____________________

C. Recursos (p. ej.: auto, cuenta bancaria, etc.) ☐ Sí ☐ No
Si respondió Sí, favor de dar una explicación ____________________.
(Adjunte copia de comprobante de cuenta bancaria, título del auto etc.)

D. Pagos de manutención de niños que usted efectúe a alguien que no es parte de su hogar: ☐ Sí ☐ No
Si respondió Sí, Aumento ☐ Reducción ☐ Nueva cantidad $__________ (Adjunte comprobante de orden judicial)

E. Gastos médicos pagados por un miembro del hogar que está incapacitado o tiene 60 años de edad o más: ☐ Sí ☐ No
Si respondió Sí, favor de dar una explicación por el cambio: ____________________

F. Otros cambios: ☐ Sí ☐ No
Si respondió Sí, favor de dar una explicación: ____________________

SAMPLE

Programa de Asistencia de Nutrición Suplementaria (SNAP)

Para que podamos determinar si usted puede continuar recibiendo beneficios de SNAP, usted debe llenar este Cuestionario de Elegibilidad y regresarlo para la fecha que aparece en la **primera página** de este formulario. Si no llena y regresa el Cuestionario de Elegibilidad para la fecha límite indicada, se reducirán o se descontinuarán sus beneficios de SNAP. En tal caso, le enviaremos otro aviso. Esta decisión se basa en la Regla 18 NYCRR 387.17.

Lista de cambios, relativos al programa de SNAP, que usted debe reportar en este momento:

- Cambios en la **fuente de ingresos** de algún miembro del hogar.
- Cambios en el total de **ingresos salariales** del hogar cuando este total se aumente o se disminuya por más de $100 al mes.
- Cambios en el total de **ingresos no salariales del hogar provenientes de fondos públicos**, tales como beneficios de Seguro Social o beneficios del Seguro de Desempleo (UIB), cuando este total se aumente o se disminuya por más de $50 al mes.
- Cambios en el total de **ingresos no salariales del hogar, provenientes de fondos privados**, tales como pagos de manutención de niños o pagos de seguro privado de incapacidad, cuando este total se aumente o se disminuya por más de $100 al mes.
- Cambios en la cantidad por orden judicial de los **pagos para manutención de niños que usted efectúe** a un niño fuera de su hogar de SNAP.
- Cambios en **quienes viven con usted.**
- **Si usted se muda**, su nuevo domicilio, y la nueva cantidad de alquiler o hipoteca; gastos de calefacción y servicios públicos.
- **Un automóvil nuevo o distinto**, u otro vehículo
- Aumento en la cantidad del hogar en **dinero en efectivo, acciones, bonos, dinero en el banco** o en una institución de ahorros cuando el total del dinero en efectivo y ahorros de todos los miembros del hogar sobrepase los $2,250 para el hogar que no conste de una persona anciana o con una incapacidad permanente; o $3,250 para el que conste de una persona anciana o incapacitada permanente.
- Si algún integrante de su hogar beneficiario de SNAP es un Adulto Sano sin Dependientes (“ABAWD”), usted debe informarnos si la participación en empleo u otra actividad de trabajo de esa persona fue inferior a 80 horas al mes. Usted debe proporcionarnos esa información dentro de los 10 días tras el fin de ese mes.

ASISTENCIA MÉDICA – Usted debe notificar inmediatamente a esta agencia de todo cambio de domicilio, ingresos, recursos o el número de integrantes de su hogar. Se le notificará si habrá cambios en la cobertura de Asistencia Médica.

Usted debe adjuntar copias de cartas o documentos que comprueben los cambios que haya reportado. Además, si usted o el miembro de su familia tiene trabajo (ingreso salarial), usted debe presentar los últimos cuatro talones de paga *u otra prueba de ingreso salarial bruto con el número de horas trabajadas durante los últimos 30 días* aun si el salario no ha cambiado.

Si algún miembro de su hogar de SNAP es un Adulto Sano Sin Dependientes (ABAWD), usted debe informarnos si la participación de esa persona en empleo u otras actividades es inferior a 80 horas al mes dentro de 10 días tras el final de ese mes.

Autorización de Reembolso de Beneficios de Asistencia Pública de los Pagos Retroactivos de SSI

Autorizo al comisionado de la Administración de Seguro Social (SSA) que utilice mi primer pago de SSI (es decir, mi pago retroactivo de SSI) para reembolsar al Distrito local de Servicios Sociales (SSD) la Asistencia Pública (PA) que me pague el SSD de los fondos Estatales o locales mientras que la SSA determine mi elegibilidad para el Ingreso de Seguridad Suplementario (SSI). La SSA no reembolsará al SSD la PA que fue pagado con fondos federales.

Estaré obligado(a) por esta autorización sólo si el Estado notifica a la SSA que yo y un representante del SSD la hayamos firmado. El Estado debe enviar el aviso dentro de 30 días civiles tras comparar mi archivo de SSI con mi archivo Estatal. La SSA no lo aceptará después de los 30 días. En su lugar, la SSA me enviará mi pago retroactivo de SSI conforme a las reglas de la SSA.

Sólo mi primer pago de SSI puede ser utilizado. Si mi primer pago es superior a la cantidad debida al SSD, la SSA me enviará el resto conforme a sus reglas.

La SSA puede reembolsar al SSD en dos circunstancias:

(1) Reembolsará al SSD si yo presento solicitud para SSI y la SSA me determine elegible.

(2) Reembolsará al SSD si se restablecen mis beneficios de SSI tras la terminación o suspensión de los mismos.

La SSA sólo reembolsará al SSD la PA que me pagó durante el período que estoy esperando que la SSA determine mi elegibilidad. Esto se denomina "asistencia interina". El período comienza (1) a partir del primer mes que soy elegible para un pago de beneficios de SSI, o (2) a partir del primer día que me restablezcan el SSI tras la suspensión o terminación del mismo. El período incluye el mes en el cual comiencen efectivamente los pagos de SSI. Si el SSD no puede suspender mi último pago de PA, el período se termina el próximo mes.

El SSD debe enviarme un aviso que me informe de la cantidad de asistencia interina pagada a más tardar 10 días tras la SSA reembolsar al SSD. Además, el aviso me informará que la SSA me enviará una carta que me indicará cómo la SSA me enviará cualquier dinero restante de SSI que se me deba, y cómo puedo presentar una apelación al estado contra la decisión si no estoy de acuerdo con la misma.

Conforme a sus reglas, la SSA puede usar la fecha en que yo firme esta autorización como fecha inicial de mi elegibilidad para SSI. Se tomará este paso sólo si presento solicitud para SSI dentro de los próximos 60 días.

Esta autorización concierne cualquier solicitud o apelación de SSI que yo tenga pendiente ante la SSA.

Esta autorización se terminará si se toma una decisión final respecto a mi caso de SSI. Se terminará cuando la SSA efectúe mi pago inicial. El Estado y yo también podemos acordar finalizar la autorización. Debo firmar una nueva autorización conforme a las reglas del Estado de Nueva York, si vuelvo a presentar solicitud para SSI tras terminar esta autorización, o si presento una nueva reclamación de SSI mientras que yo tenga pendiente una solicitud o apelación de SSI.

Se me otorgará una oportunidad para una audiencia imparcial si no estoy de acuerdo con cualquier decisión tomada por el SSD respecto al reembolso.

Recibí una copia del panfleto denominado "Lo que Usted Debería Saber Sobre los Programas de Servicios Sociales." Entiendo lo que estipula dicho panfleto respecto a asistencia interina.

Juro (o) afirmo que los datos que he proporcionado en este formulario son verdaderos y exactos.

Nombre (Letra de Molde): ______________________________

Firma: ______________________________ Fecha: ____________

Firma del Esposo(a) o Representante Autorizado: ______________________________ Fecha: ____________

ADVERTENCIA: Las leyes federales y estatales disponen sanciones en la forma de multas, encarcelamiento o ambos, si usted no declara la verdad o si oculta o no revela datos pertinentes respecto a su elegibilidad continua para asistencia. El reglamento estipula que usted notifique inmediatamente a esta agencia todo cambio en sus necesidades, ingresos, recursos, situación de vivienda o domicilio.

Firma del Trabajador: ______________________________ Fecha: ____________

NOTA: La última parte de este formulario es una solicitud de registro de votante. Si necesita ayuda para llenar la solicitud de registro de votante, pídasela a su trabajador(a). La inscripción o no para votar no afecta de ninguna manera la decisión de esta agencia en cuanto a la cantidad de concesiones que se le otorgue a usted. Regrese este formulario a la Agencia, aunque no lo haya llenado completamente.

SAMPLE

Human Resources Administration
Department of Social Services
Family Independence Administration

Routing Control Sheet

☐ **Photo ID card** ☐ **Medicaid card**

Receptionist/CSIC: ______________________ Case Number: ______________

Name: ____

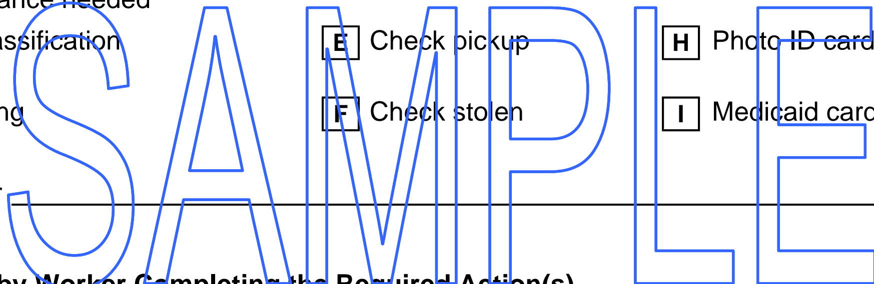
Assigned to: ______________________ Time: ________ Date: __________

Address: ____

Forward to: A. ______________________ B. ______________________

Purpose of Visit: ____

Required Action(s)



- A Address change/no special allowance needed
- B Reclassification
- C Closing
- D Acceptance
- E Check pickup
- F Check stolen
- G Check lost
- H Photo ID card
- I Medicaid card
- J Other ____

To Be Completed by Worker Completing the Required Action(s)

Narrative of service given and case status (history): ______________________

____

____

____

____

____

____

____

____

______________________ ______________
Worker's Signature Date

______________________ ______________
Supervisor's Signature Date